

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified or page 4 must be completed.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1- FOR STATE REGISTRAR		8 2 1 2 9 0 4 REG. NO.							
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Alice W Adams					2a. DATE OF DEATH MONTH DAY YEAR May 10th 1982			2b. HOUR 9:50 P	
3. SEX Female		4. RACE Negro		5. DATE OF BIRTH MONTH DAY YEAR Dec. 27, 1905		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS 76		7. IF UNDER 1 YEAR IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Charles County MD.			
10. CITY OR TOWN OF DEATH LaPlata		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT HOSPITAL, CITY, STREET, AND NO.) Physicians Memorial Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE 13b. COUNTY 13c. CITY OR TOWN Maryland Charles Waldorf									
14. FATHER'S NAME FIRST MIDDLE LAST Jeff Gray		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sarah Wallace							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 217-30-0527		17. INFORMANT Bonnie		17b. ADDRESS Box 428 Marbray, Md. 20658			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary edema 1429 DUE TO, OR AS A CONSEQUENCE OF (b) congestive heart failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) carcinomatosis 2 1/2 yrs APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 hours 6 weeks									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) metastatic salivary gland carcinoma to liver, lung, bone									
19a. DATE OF OPERATION 3/23/82		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED pneumonia, perforated ulcer				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR N/A		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) N/A					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) N/A		21f. LOCATION STREET CITY OR TOWN COUNTY STATE N/A					
22a. I certify that (I) (this hospital) attended the deceased from 3/9 , 19 78 , to 5/4 , 19 82 , that (I) (we) last saw the deceased alive on 4/24 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (we) (I) (did) (did not) see the body after death.									
22b. SIGNATURE Paul E. Pritchett				DEGREE M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 5/11/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Paul E. Pritchett, M.D.				22e. ADDRESS 118 La Grange Ave, La Plata, Md. 20646					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 5/15/1982		23c. NAME OF CEMETERY OR CREMATORY St. Peters Ch. Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Waldorf Chas. Md.			
24. FUNERAL DIRECTOR NAME Martell Adams				24b. ADDRESS Adams Funeral Home Aquasco, Md.		25a. DATE REC'D. BY REGISTRAR MAY 25 1982		25b. REGISTRAR'S SIGNATURE James J. Hester	

8 2 1 2 9 7

Dec. 2, 1952

Charles Connor

USA

Belice

New York, New York

Sam Wallace

Box 123

21 - 0 - 0527 Sam Taylor

Harvey, N.Y. 10001

WALSH & SONS

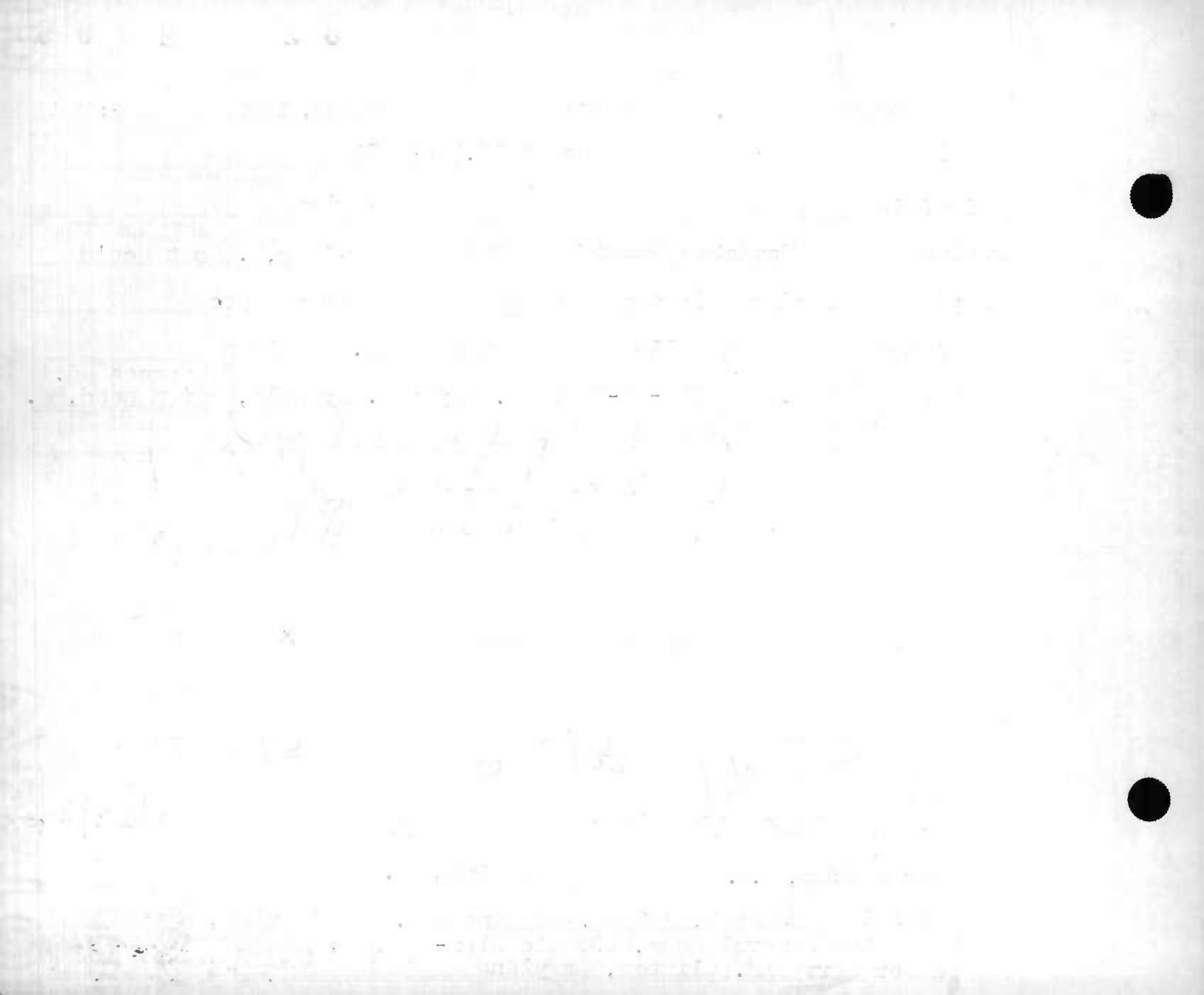
WALSH & SONS

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 2 1 2 9 0 5			
FOR 1. STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) NOLAN J. BRAMELL			2a. DATE OF DEATH MONTH DAY YEAR May 28, 1982		2b. HOUR 9:00 A.M.		
3 SEX XXXXX MALE	4 RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR August 17, 1909		6. AGE (IN YEARS LAST BIRTHDAY) 72		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Charles MD.			
10. CITY OR TOWN OF DEATH La Plata	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Physicians Memorial Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Welder, U.S. Govt Ret'd		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE Maryland		13b. COUNTY Charles	13c. CITY OR TOWN Indian Head	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS Theresa Apts		
14. FATHER'S NAME FIRST MIDDLE LAST Milton Bramell			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Emma R. Rison				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW II 220-09-0089		17. INFORMANT ADDRESS 8 Cypress Rd. Mr. Wayne H. Bramell, Indian Head, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Cordial failure</u> 4960 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <u>Due to, OR AS A CONSEQUENCE OF, Myocardial Infarction</u> (c) <u>Due to, OR AS A CONSEQUENCE OF, Chronic Obstructive Pulmonary Disease</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>5/28</u> 19 <u>82</u> , to <u>5/28</u> 19 <u>82</u> , that (I) (we) lost saw the deceased alive on <u>5/28</u> 19 <u>82</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>George Wathen</u>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 5/28/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) George Wathen, M.D.		22e. ADDRESS La Plata, Md.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE June 1, 1982		23c. NAME OF CEMETERY OR CREMATORY Md. Veterans Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Cheltenham, Maryland	
24. FUNERAL DIRECTOR NAME Lee Funeral Home, 6633 Old Alexander Ferry Rd. Clinton, Maryland		25a. DATE RECD. BY REGISTRAR JUN 3 1982		25b. REGISTRAR'S SIGNATURE <u>James J. Smith</u>			



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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at 1-800-251-1533.

MEDICAL CERTIFICATION

1. FOR STATE REGISTRAR				STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 2 1 2 9 0 6			
1. DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH				2b. HOUR			
FIRST MIDDLE LAST William Morgan BURDETTE, Sr.				MONTH DAY YEAR May 12, 1982				11:40 A.M.			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Feb. 9, 1907		6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Delaware		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Charles County MD.					
10. CITY OR TOWN OF DEATH La Plata		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Physicians Memorial Hospital				12a. USUAL OCCUPATION (TYPE OF WORK OR MAIN SOURCE OF LIVING) Industrial Engineer		12b. KIND OF BUSINESS OR INDUSTRY U.S.N.O.S.			
13a. STATE Md.				13b. COUNTY Charles		13c. CITY OR TOWN La Plata		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 300 Arlington Drive	
14. FATHER'S NAME FIRST MIDDLE LAST John Purdum Burdette				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Emma Jones				16. ADDRESS 300 Arlington Dr., La Plata, Md.			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) * No				16b. SOCIAL SECURITY NO. 579-20-7544		17. INFORMANT Mrs. Myrtle A. Burdette-Wife					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>NEOPLASTIC PERITONITIS - TOXEMIA.</u> <u>1533</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>ADENOCARCINOMA OF COLON (SIGMOID)</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) <u>2 METASTASES.</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION <u>5-6-82</u>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>ADENOCARCINOMA OF COLON - OBSTRUCTION</u>				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <u>4-29-82</u> , 19 <u>82</u> , to <u>5/12/82</u> , 19 <u>82</u> , that (I) (we) lost saw the deceased alive on <u>5/12/82</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>J. PARRAN JARBOE M.D.</u>				DEGREE <u>SURGEON</u> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 5/12/82			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS <u>JARWOOD CLINIC - LA PLATA MD 2064</u>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 5/15/82		23c. NAME OF CEMETERY OR CREMATORY Trinity Mem. Gardens		23d. LOCATION CITY OR TOWN COUNTY STATE Waldorf Charles County Md.		25a. DATE REC'D. BY REGISTRAR MAY 18 1982			
24. FUNERAL DIRECTOR NAME Arehart Funeral Home, Inc. - La Plata, Md.				25b. REGISTRAR NAME [Signature]							



Male

White

Feb. 2, 1907

75

Charles Court

U.S.A.

Delaware

In Place

Physicians Memorial Hospital

Retired U.S.A.

Id.

Charles A. Place

300 Clinton Drive

John Burton Burdette

Id.

James

300 Clinton Dr., In Place, Id.

190-10-754 Mrs. Myrtle A. Burdette - Id.

Id.

Burial

247483

Trinity Mem. Gardens

Id.

Archard Funeral Home, Inc. - In Place, Id.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)				2a. DATE KNOWN OF DEATH				2b. DATE OF DEATH				2c. DATE PRONOUNCED DEAD			
John Chester Caldwell				5 27 19 82				5 27 19 82				11 A			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS)		7. IF UNDER 1 YR.		8. IF UNDER 24 HRS.		9. BALTIMORE CITY OR COUNTY OF DEATH			
Male		White		July 20-43		38 YRS.		MONTHS		DAYS		Charles County, MD			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)				7b. CITIZEN OF WHAT COUNTRY?				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>							
Washington DC				USA											
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY			
La Plata				Physicians Memorial Hospital				Dispatcher				Retail Ind			
13a. STATE				13b. CITY OR TOWN				13c. INSIDE CITY LIMITS?				13d. STREET ADDRESS			
Maryland				Pr George				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				5509 Deer Pond Lane			
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME				16a. WAS DECEASED EVER IN U.S. ARMED FORCES?				16b. SOCIAL SECURITY NO.			
Charles Caldwell				Beulah Waybright				Yes				578 54 7486			
17. INFORMANT				18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
Same as #13				PART I DEATH WAS CAUSED BY:											
				IMMEDIATE CAUSE (a) Multiple injuries											
				DUETO, OR AS A CONSEQUENCE OF											
				(b) DUETO, OR AS A CONSEQUENCE OF											
				(c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).															
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?							
								YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY				21c. HOW INJURY OCCURRED							
4 5 27 19 82				Driver in auto/fixed object impact											
21d. INJURY OCCURRED				21e. PLACE OF INJURY				21f. LOCATION							
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				road				Rt. 5 at \$5. 488				Charles Md.			
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>															
ACTUAL SIGNATURE				TITLE (SPECIFY)				DATE SIGNED							
Thomas D. Smith, M.D.				M.D. Deputy Chief				5/28/82							
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS											
Thomas D. Smith, M.D.				111 Penn St. Balto., MD.											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION			
Burial				1 June 82				Washington National				Suitland PG Md			
24. FUNERAL DIRECTOR				25. DATE REC'D. BY REGISTRAR				26. REGISTRAR'S SIGNATURE							
Robert E. Wilhelm				June 3 1982											
NAME				ADDRESS											
Funeral Home				Suitland, Md.											

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

BP
DHMH-17
(VR A15 ME (5))
15M 2/80

1904

NO. 12

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 2 1 2 9 0 8
1. FOR STATE REGISTRAR										REG. NO.
1. DECEASED NAME (TYPE OR PRINT) Howard Norman Chambers Sr.						2a. DATE OF DEATH MONTH DAY YEAR 5-6-82		2b. HOUR 10 ²⁵ A.M.		
3. SEX male		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR March 28 1910		6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Charles MD.				
10. CITY OR TOWN OF DEATH LaPlata		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Physicans Memorial Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Policeman		12b. KIND OF BUSINESS OR INDUSTRY U.S. Gov White House		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)										
13a. STATE Md.		13b. COUNTY Charles		13c. CITY OR TOWN LaPlata		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS Rt. 3, Box 57		
14. FATHER'S NAME FIRST MIDDLE LAST George E. Chambers				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ellen Kennedy						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes				16b. SOCIAL SECURITY NO. 577-09-0633		17. INFORMANT ADDRESS Elbie V. Chambers, Same as # 13				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u>										
4100 DUE TO, OR AS A CONSEQUENCE OF (b) _____										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) _____										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>Chronic Obstructive Pulmonary Disease</u>										
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>										
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <u>4-17</u> , 19 <u>75</u> , to <u>5-6</u> , 19 <u>82</u> , that (I) (we) saw the deceased alive on <u>11-3</u> , 19 <u>81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <u>Henry L. Burke</u>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 5-6-82		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Henry L. Burke				22e. ADDRESS LaPlata, Md. 20646						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 5-8-82		23c. NAME OF CEMETERY OR CREMATORY Trinity Memorial Gdns, Waldorf, Chas. Md.		23d. LOCATION CITY OR TOWN COUNTY STATE		
24. FUNERAL DIRECTOR NAME HUNT + FUNERAL HOME WALDORF MD.				25a. DATE REC'D. BY REGISTRAR MAY 11 1982		25b. REGISTRAR'S SIGNATURE <u>James J. [Signature]</u>				

Hunt + Funeral Home Wanda Inc.

1970

1970

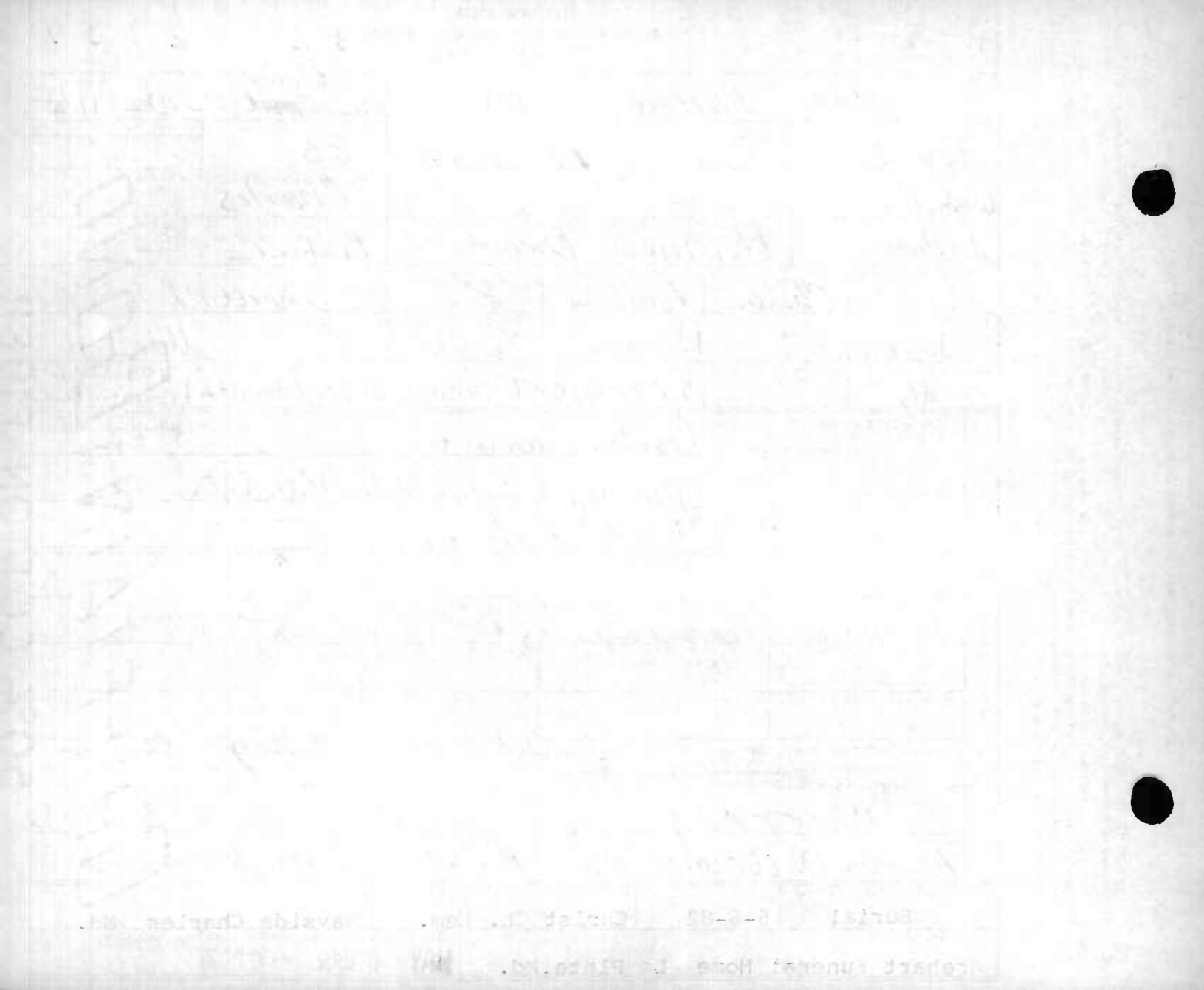
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 2 1 2 9 0 9			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) <i>Macy Florence Chesser</i>				2a. DATE (MONTH DAY YEAR) <i>April 03 1982</i>		2b. HOUR <i>11:45</i> M	
3. SEX <i>Female</i>		4. RACE <i>Can.</i>		5. DATE OF BIRTH (MONTH DAY YEAR) <i>12 31 1898</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>83</i> YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Wash. D.C.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Charles</i> MD.	
10. CITY OR TOWN OF DEATH <i>La Plata</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Physicram Almaral</i>		12a. USUAL OCCUPATION (TYPE OR WORK FOR MOST OF WORKING LIFE) <i>Banker</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>-</i>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) <i>1300 N. Charles</i>				13b. CITY OR TOWN <i>Columbia Island</i>		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME (FIRST MIDDLE LAST) <i>Joseph J. Norman</i>		15. MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST) <i>Sarah Marshall</i>		13d. STREET ADDRESS <i>2 Bennett Rd.</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>		16b. SOCIAL SECURITY NO. <i>577-05-8898</i>		17. INFORMANT ADDRESS <i>1103 S.W. 6th Ave Boynton Beach, Fla</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac arrest</i> 4292 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <i>Generalized arteriosclerotic heart disease</i> yes (c) <i>Fractured hip - right</i>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>1m</i>			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION <i>14 April 82</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Fractured hip - right</i>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <i>19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <i>26 Oct</i> , 19 <i>68</i> , to <i>3 May</i> , 19 <i>82</i> , that (I/we) lost saw the deceased alive on <i>3 May</i> , 19 <i>82</i> , and that in (my) (our) opinion death occurred on the dot and hour and from the causes stated above, (I/we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Arthur C. Woody</i>		DEGREE <i>MD</i>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>3 May 82</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>ARTHUR C. WOODY MD</i>		22e. ADDRESS <i>Box 430 LA PLATA, MD 20646</i>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>5-6-82</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Christ Ch. Cem.</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Wayside Charles, Md.</i>	
24. FUNERAL DIRECTOR NAME <i>Arehart Funeral Home</i>				25a. DATE REC'D. BY REGISTRAR <i>MAY 6 1982</i>			
ADDRESS <i>La Plata, Md.</i>				25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 2 1 2 9 1 0 REG. NO.			
1. FOR STATE REGISTRAR		I. DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH				MONTH DAY YEAR		2b. HOUR	
		WILLARD D COLE				4-27-82				10 15		M	
3 SEX		4 RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS			
MALE		BLACK		FEB. 3 1932		50 YRS		MONTHS DAYS		HOURS MIN.			
7a. BIRTHPLACE (COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH							
NORTH CAROLINA		USA				CHARLES MD.							
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)								12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
LA PLATA		PHYSICIANS MEMORIAL HOSPITAL								TRUCK DRIVER		PRIVATE	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS			
Virginia		HALIFAX		S. BOSTON		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				VIRGINIA		GEN. DELIVERY S. BOSTON	
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME									
FIRST MIDDLE LAST				FIRST MIDDLE LAST									
WILLIE COLE				ETTA WILKERSON									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS							
YES				1952; 1954		BETTY J. WARNER 2016 King Charles							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
IMMEDIATE CAUSE (a) <u>Meningitis</u>													
4860 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Pneumonia</u>													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.													
DUE TO, OR AS A CONSEQUENCE OF (c)													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)													
<u>Septicemia, Gastro Intestinal Bleeding</u>													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
								YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY		21c. HOW INJURY OCCURRED		(ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
				HOUR A.M. MONTH DAY YEAR									
21d. INJURY OCCURRED				21e. PLACE OF INJURY		21f. LOCATION							
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				[AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.]		STREET		CITY OR TOWN		COUNTY		STATE	
22a. I certify that (1) (this hospital) attended the deceased from <u>4-24</u> , 19 <u>82</u> , to <u>4-27</u> , 19 <u>82</u> , that (1) (we) lost saw the deceased alive on <u>4-27</u> , 19 <u>82</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) did (did not) view the body after death.													
22b. SIGNATURE				DEGREE				22c. DATE SIGNED					
<u>Henry L Burke M.D.</u>								4-27-82					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS									
HENRY L BURKE, M.D.				LA PLATA, MARYLAND 20646									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION					
BURIAL				MAY 4, 1982		CHURCH CEMETERY		CITY OR TOWN		COUNTY		STATE	
24. FUNERAL DIRECTOR				25. DATE OF REGISTRATION									
<u>Stanley S. Smith</u>				MAY 24 1982									

6 1 5 2

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 2 1 2 9 1 1 REG. NO.			
1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST CARL Herman CRAMER				2b. HOUR 2:30am			
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR Sept. 12 1889		6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS 92 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Ohio		7b. CITIZEN OF WHAT COUNTRY? U.S. A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH CHARLES MD.	
10. CITY OR TOWN OF DEATH LA PLATA		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PHYSICIANS MEMORIAL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Real Estate		12b. KIND OF BUSINESS OR INDUSTRY So.Md.Realty	
13a. STATE Maryland				13b. COUNTY Charles		13c. CITY OR TOWN La Plata	
13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				13e. STREET ADDRESS Ripley Park			
14. FATHER'S NAME FIRST MIDDLE LAST Harry Cramer				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Caroline M. Neuman			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) Yes 1906		16b. SOCIAL SECURITY NO. 214-36-1678		17. INFORMANT ADDRESS Anna Marie Cramer, La Plata, Md. 20646			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Failure 2391 DUE TO, OR AS A CONSEQUENCE OF (b) Multiple Tumors in lung DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (1) (this hospital) attended the deceased from 4-30 , 19 82 , to 5-1 , 19 82 , that (1) (we) last saw the deceased alive on 4-30 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Henry L Burke MD		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 5-1-82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) HENRY L BURKE, M.D.				22e. ADDRESS LA PLATA, MARYLAND 20646			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 05/04/82		23c. NAME OF CEMETERY OR CREMATORY Trinity Me. Gardens		23d. LOCATION CITY OR TOWN COUNTY STATE Charles Md.	
24. FUNERAL DIRECTOR NAME ADDRESS Arehart Funeral Home, Inc., La Plata, Md.				25a. DATE REC'D. BY REGISTRAR MAY 6 1982			
				25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE									
1. FOR STATE REGISTRAR		8 2 1 2 9 1 2				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Winfred Hoover Eaton						2a. DATE OF DEATH MONTH DAY YEAR 5-6-82		2b. HOUR 5:30 P.M.	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 1 13 29		6. AGE (IN YEARS LAST BIRTHDAY) 53 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Wash. D.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Charles MD.			
10. CITY OR TOWN OF DEATH La Plata		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION Physicians Memorial Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Machinist		12b. KIND OF BUSINESS OR INDUSTRY U.S. Gov't	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE Maryland		13b. COUNTY Charles		13c. CITY OR TOWN Indian Head		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS Rt. #1 Box 455-A	
14. FATHER'S NAME FIRST MIDDLE LAST Merle E. Eaton					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Emma J. Gilroy				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. Korean		17. INFORMANT Norma I. Eaton, same as 13		ADDRESS			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) HEART FAILURE 1629 DUE TO, OR AS A CONSEQUENCE OF (b) FLUID & ELECTROLYTE IMBALANCE DUE TO, OR AS A CONSEQUENCE OF (c) CANCER OF RIGHT LUNG - OPERATED APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 day 1 WEEK 2 years									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) Chemotherapy Effect.									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>MARCH 1975</u> to <u>MAY 5, 1982</u> , that (I) (we) lost saw the deceased alive on <u>APRIL 28, 1982</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Aurelio C. de la Paz, M.D.				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 5-6-82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) AURELIO C. DE LA PAZ, MD				22e. ADDRESS P.O. Box 1230, LA PLATA, MD 20646					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 5-10-82		23c. NAME OF CEMETERY OR CREMATORY Trinity Mem. Gardens		23d. LOCATION CITY OR TOWN COUNTY STATE Waldorf, Charles, Md.			
24. FUNERAL DIRECTOR NAME Huntt Funeral Home, Waldorf, Maryland				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE [Signature]			

BP

2-1-52

Power

White

Chassis

U.S. Post

Physician's Hospital & Clinic

Box 22-1

Box 22-1

Slip

Slip

Slip

Slip

Box 22-1

Box 22-1

2-2-52

Box 22-1

Box 22-1

Box 22-1

BP _____

DHMH - 16 50M 1/B1
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1. FOR STATE REGISTRAR		8 2 1 2 9 1 3		REG. NO.							
1 DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR	
Harold		N/M/N		Garrett		May 7, 1982		1:40P M			
3 SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
Male		White		June 20, 1916		65 YRS					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
South Carolina		U.S.A.				Charles		MD.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
La Plata		Physicians Memorial Hospital		Truck Driver		Trucking Co.					
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS			
Md.		Charles		La Plata				Rt.#3 Box 38-A			
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST									
John W. Garrett		Sally		Watson							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT ADDRESS							
NO		579-05-0207		Regina Garrett		same as #13					
18. CAUSE OF DEATH (Enter only one cause per line (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory failure</u> (b) <u>metastatic disease of liver</u> (c) <u>status post cancer of lung</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
12/1/82		Metastatic disease of liver									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18; PART 1 OR PART 2)							
		P.M. 19									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NO: WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from April 25, 1982, to May 7, 1982, that (I) (we) last saw the deceased alive on May 6, 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED					
		M.D.				5-7-82					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS									
Nirendra A. Bhaduri M.D.		Waldorf, Md									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE					
Burial		5-10-82		Trinity Mem. Garden		Charles Maryland					
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
Arehart Funeral Home		La Plata, Md.		MAY 17 1982		Rene J. [Signature]					

MEDICAL CERTIFICATION

43

NAME

June 20, 1916

Address

Mail

South Carolina, U.S.A.

Trucking Co. Truck Driver

Box 38-A

X

Charles W. Glass

Charles W. Glass

Mr.

Station

Sally

John W. Garrett

570-27-0207 Radio Garrett

10

Handwritten notes:
The above is a copy of a letter
sent to the above named person
on the above date.

82

May 7

May 6

May 6

Special 2-10-82 Trinity Mem. Garden Wicket Charles Maryland

Atendant Funeral Home - La Vista, Md.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1. FOR STATE REGISTRAR		8 2 1 2 9 1 4									
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR	
WILLIAM Robert		GOLDSMITH, Sr.						May 5, 1982		9:30 PM	
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR MONTHS DAYS		7. IF UNDER 24 HRS. HOURS MIN.	
Male		Caucasian		March 28 1927		55					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
Maryland		U.S.A.				Charles MD.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
La Plata		Physicians Memorial Hospital						Carpenter		U.S. Govt.	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS			
Md.		St. Marys		Mechanicsville				Rt. 5, Box 22			
14. FATHER'S NAME FIRST MIDDLE LAST				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST							
James H. Goldsmith				Rosa M. Goldsmith							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS					
Yes				W.W. II		577-40-4367 Dorothy B. Goldsmith, Same as # 13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 5184										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DUE TO, OR AS A CONSEQUENCE OF (b) ACUTE PULMONARY OEDEMA											
DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 0											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from 5/2/82 to 5/5/82, that (I) (we) last saw the deceased alive on 5/5/82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Ramakrishna				DEGREE				22c. DATE SIGNED 5/5/82			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS							
Nallan C. Ramakrishna M.D.				Waldorf, Md 20601							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE					
Burial		5-8-82		Trinity Memorial Gdns.		Waldorf, Chas. Md.					
24. FUNERAL DIRECTOR NAME						25a. DATE REC'D. BY REGISTRAR REGISTRAR'S SIGNATURE					
Huntt Funeral Home, Waldorf, Maryland						MAY 11 1982					

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PW 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DHMH - 17
(VR A15 ME (1))
15M 2/80

FOR STATE REGISTRAR										STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 12915	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST JOSEPH CARLISLE GREER SR										2a. DATE KNOWN OF DEATH MONTH DAY YEAR 5-30-82					2b. HOUR 9:06A						
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 3-28-1902		6. AGE (IN YEARS LAST BIRTHDAY) 80 YRS.		7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 5-30-82		7d. HOUR 9:06A											
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Welcome, Maryland				7b. CITIZEN OF WHAT COUNTRY? U.S.A.				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Charles County									
10. CITY OR TOWN OF DEATH Residence Welcome				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Box 1060 Welcome Md.						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Farmer				12b. KIND OF BUSINESS OR INDUSTRY Farming							
13a. STATE Md.		13b. COUNTY Charles		13c. CITY OR TOWN Welcome		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS Rt. #1 Box 260													
14. FATHER'S NAME FIRST MIDDLE LAST John Samuel Greer, Sr.										15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Carol McCarthy											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO				(IF YES, GIVE WAR OR DATES)				16b. SOCIAL SECURITY NO. 215-38-5083A				17. INFORMANT ADDRESS Katie M. Greer same as #13									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Shotgun wound of head</u> 9554 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																					
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? HEAD ONLY YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR ? 5-30-82 P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) self/inflicted													
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) carport of				21f. LOCATION STREET CITY OR TOWN COUNTY STATE Box 1060 Welcome, Maryland													
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																					
ACTUAL SIGNATURE Margarita A. Korell				TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER								DATE SIGNED 5-31-82									
EXAMINER'S NAME (TYPE OR PRINT) Margarita A. Korell, M.D.				ADDRESS 111 Penn Street																	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 6-2-82		23c. NAME OF CEMETERY OR CREMATORY St. Ignatius Ch. Cem.				23d. LOCATION CITY OR TOWN COUNTY STATE Hilltop Charles Maryland											
24. FUNERAL DIRECTOR NAME ADDRESS Arehart Funeral Home La Plata, Maryland				25a. DATE REC'D. BY REGISTRAR JUN 4 1982				25b. REGISTRAR'S SIGNATURE													

MEDICAL CERTIFICATION

Arthur Funeral Home La Plata, Maryland

burial 12-7-62 22. Ignacio C. Rodriguez, Mexico

into white 3-5-1902 1 20

Alonso, Maryland

Alonso, Mexico

Alonso, Mexico

Alonso, Mexico

Alonso, Mexico

X

Alonso, Mexico

Alonso, Mexico

Alonso, Mexico

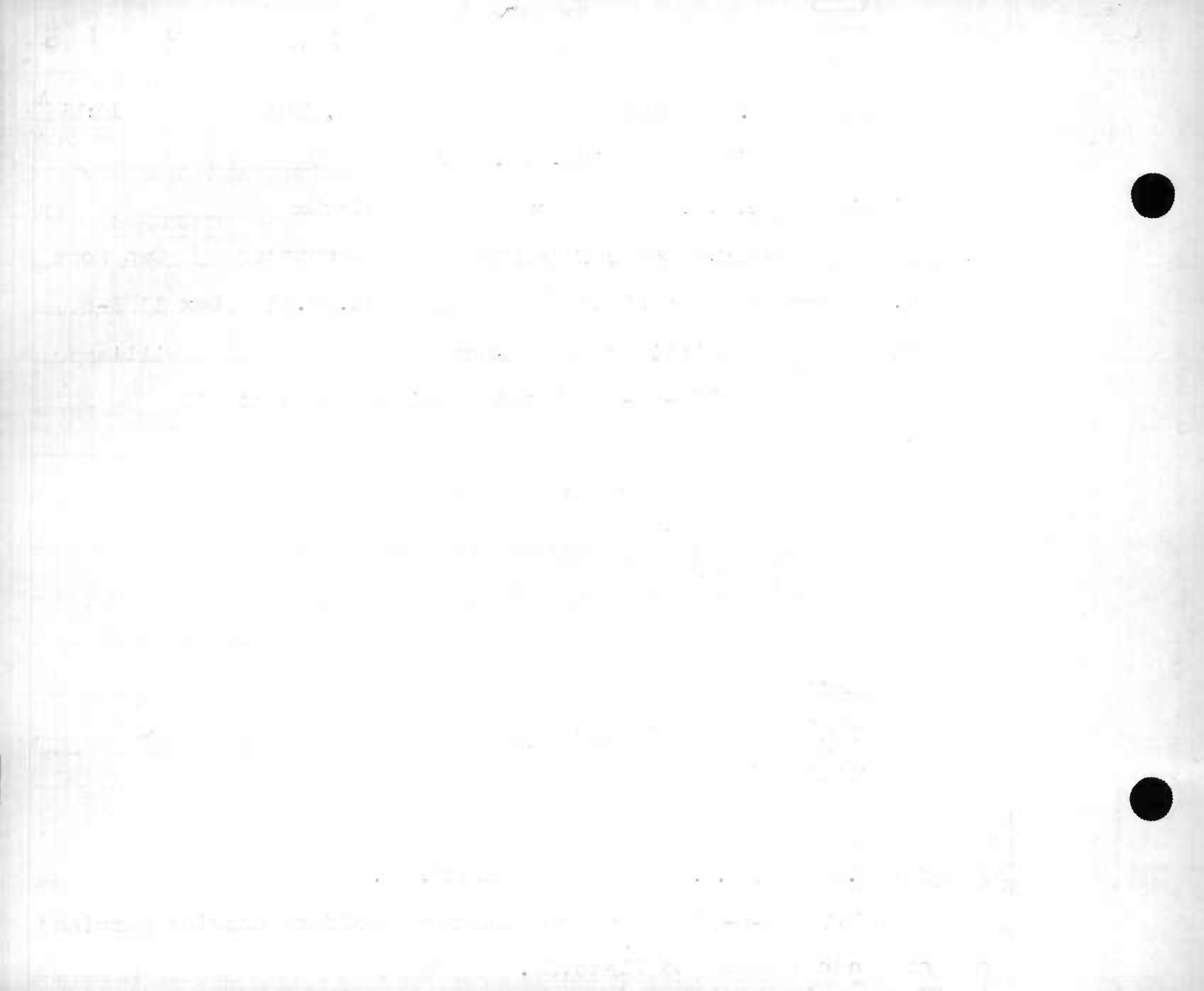
Alonso, Mexico

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 2 1 2 9 1 6 REG. NO.					
1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR				2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Nadine Mae Grimes				May 6, 1982				10:15 A M	
3 SEX Female		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR Aug. 28, 1916		6 AGE (IN YEARS LAST BIRTHDAY) YRS. 65		7 UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Illinois		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Charles MD.			
10. CITY OR TOWN OF DEATH La Plata		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Physicians Memorial Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Own Home			
13a. STATE Md.				13b. CITY OR TOWN Charles		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13d. STREET ADDRESS St. Rt. #1 Box 1183-B	
14. FATHER'S NAME FIRST MIDDLE LAST Walter Williams				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anna Williams					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO				16b. SOCIAL SECURITY NO 220-62-9523		17. INFORMANT ADDRESS Walter Grimes same as #13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MASSIVE CEREBROVASCULAR ACCIDENT 4360 DUE TO OR AS A CONSEQUENCE OF WITH BRAIN DEATH. PND DIABETIC KETOACIDOSIS DUE TO OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): HYPERTENSION, DIABETES									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input checked="" type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 4/29/82 19, to 5/6/82 19, that (I) (was) last saw the deceased alive on 5/6/82 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Sanjeeb K. Mishra, M.D.				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (Last, first, middle) Sanjeeb K. Mishra, M.D.				22e. ADDRESS Waldorf, Md.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 5-8-82		23c. NAME OF CEMETERY OR CREMATORY Oakland Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Waldorf Charles Maryland			
24. FUNERAL DIRECTOR NAME Arehart Funeral Home				ADDRESS La Plata, Md.		25a. DATE REC'D. BY REGISTRAR MAY 11 1982		25b. REGISTRAR'S SIGNATURE	



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.

TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DHMH - 17
(VR A15 ME (5))
15M 2/80

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 12917					
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST David Scott Keesee										2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> ESTIMATED <input type="checkbox"/> MONTH DAY YEAR 5 12 19 82					
3. SEX male		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR Mar. 2, 1965 17 YRS.		6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN. 17		7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 5 12 19 82		7b. HOUR 2:05 PM					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Charles		10. CITY OR TOWN OF DEATH LA PLATA		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Physician's Memorial Hospital					
12a. USUAL RESIDENCE (IF IN RESIDENCE HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) Md.		12b. COUNTY Charles		12c. CITY OR TOWN Welcome		12d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		12e. STREET ADDRESS Box 17		12f. KIND OF BUSINESS OR INDUSTRY High Sch.					
14. FATHER'S NAME FIRST MIDDLE LAST Willard Lee Keesee, Sr.				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Verna Purcell				16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO							
16b. SOCIAL SECURITY NO. 216-92-0450				17. INFORMANT Willard L. Keesee, Sr.				ADDRESS same as #13							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gunshot wound of chest</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										WEAPON: Rifle		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).															
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 12:50 A.M. 5/12 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) self inflicted wound							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) dirt road				21f. LOCATION (CITY OR TOWN, COUNTY, STATE) Windmill Pt Rd, Welcome, Chas. County, MD							
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>															
ACTUAL SIGNATURE Thomas D. Smith, M.D.				TITLE (SPECIFY) Deputy Chief						DATE SIGNED 5/13/82					
EXAMINER'S NAME (TYPE OR PRINT) Thomas D. Smith, M.D.				ADDRESS 111 Penn Street, Balto. MD 21201											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 5-15-82		23c. NAME OF CEMETERY OR CREMATORY Trinity Mem. Garden				23d. LOCATION (CITY OR TOWN, COUNTY, STATE) Waldorf Charles Maryland					
24. FUNERAL DIRECTOR NAME Arehart Funeral Home				ADDRESS La Plata, Md.				25a. DATE REC'D. BY REGISTRAR MAY 18 1982				25b. REGISTRAR'S SIGNATURE 			



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 2 1 2 9 1 8 REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) Anne Marie Lathroum				2a. DATE OF DEATH MONTH DAY YEAR May 26, 1982				2b. HOUR 1:36 P.M.	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR May 26, 1982		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS 24		IF UNDER 1 YEAR IF UNDER 24 HRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) LaPlata, Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Charles MD.			
10. CITY OR TOWN OF DEATH LaPlata		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Physicians Memorial Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md. 13b. CITY OR TOWN St. Mary's 13c. STREET ADDRESS Oakville				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS Box 163 Laurel Grave Rd.			
14. FATHER'S NAME FIRST MIDDLE LAST Richard Wayne Lathroum				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Wanda Jacqueline Shotwell					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Richard W. Lathroum same					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Non viable fetus DUE TO, OR AS A CONSEQUENCE OF (b) Immaturity Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (c) Immaturity								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 5/26, 1982 to 5/26, 1982 , that (I) (we) lost saw the deceased alive on 5/26, 1982 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE A. Alam				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Aziza Alam, M.D.				22e. ADDRESS Waldorf, Maryland 20601					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE May 27'82		23c. NAME OF CEMETERY OR CREMATORY Chas. Mem. Gardens Leonardtown		23d. LOCATION CITY OR TOWN COUNTY STATE St. Marys Md.			
24. FUNERAL DIRECTOR NAME ADDRESS W. Clarke Mattingley Leonardtown, Md.				25a. DATE REC'D. BY REGISTRAR JUN 1 1982		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 2 1 2 9 1 9 REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) William Stephen Maggi				2a. DATE OF DEATH MONTH DAY YEAR May 15, 1982			
3. SEX Male				2b. HOUR a 2:02 M			
4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Aug. 1, 1932		6. AGE (IN YEARS LAST BIRTHDAY) 49 YRS.		IF UNDER 1 YEAR MONTHS DAYS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Charles MD	
10. CITY OR TOWN OF DEATH LaPlata		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Physicians Memorial Hospital Training Offer. U.S. Govt.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Md.		13b. COUNTY Charles		13c. CITY OR TOWN La Plata		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Stephen Maggi		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Jean O'Brien		13e. STREET ADDRESS Box 123 #6 Somerset St.			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) YES		16b. SOCIAL SECURITY NO. Korea/Viet 116-24-1281		17. INFORMANT ADDRESS Ann J. Maggi same as #13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC ARRHYTHMIA 4149 DUE TO, OR AS A CONSEQUENCE OF (b) ISCHEMIC HEART DISEASE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost DUE TO, OR AS A CONSEQUENCE OF (c)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 5/15/82 , to 5/15/82 , that (I) (we) lost saw the deceased alive on 5/15/82 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Nallen Ramakrishna</i>		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Nallen Ramakrishna, M.D.		22e. ADDRESS Waldorf, Md. 20601					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 5-18-82		23c. NAME OF CEMETERY OR CREMATORY Md. Veterans Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Cheltenham P.G. Maryland	
24. FUNERAL DIRECTOR NAME Arehart Funeral Home		ADDRESS La Plata, Md.		25a. DATE REC'D. BY REGISTRAR MAY 18 1982		25b. REGISTRAR'S SIGNATURE <i>James J. [Signature]</i>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 2 1 2 9 2 0			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Leroy Ernest Owings				2a. DATE OF DEATH MONTH DAY YEAR May 7, 1982			
2b. HOUR 11:30^{AM}							
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR June 18, 1894		6. AGE (IN YEARS, LAST BIRTHDAY) 87	
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Charles MD.	
10. CITY OR TOWN OF DEATH La Plata		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Physicians Memorial		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) IMS. SALESMAN		12b. KIND OF BUSINESS OR INDUSTRY INSURANCE	
13a. STATE MARYLAND				13b. CITY OR TOWN MECHANICVILLE		13c. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input type="checkbox"/> NO	
13d. STREET ADDRESS RT. 4 BOX 215							
14. FATHER'S NAME FIRST MIDDLE LAST ERNEST OWINGS		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST BERTIE YOUNGER					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) YES		16b. SOCIAL SECURITY NO. 577 07 6162		17. INFORMANT ADDRESS same as 13 BETTY SPARKS, GRANDDAUGHTER			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest 4409 DUE TO, OR AS A CONSEQUENCE OF (b) arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 1965 , 19____, to 5/7/82 , 19____, that (I) (we) last saw the deceased alive on 5/4/82 , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE J. N. Thibadeau				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED May 7, 1982	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Joseph H. Thibadeau				22e. ADDRESS 3112 Alabama Avenue Washington, D.C.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 5/10/82		23c. NAME OF CEMETERY OR CREMATORY CEDAR HILL CEMETERY		23d. LOCATION CITY OR TOWN COUNTY SUITLAND, PG. MARYLAND	
24. FUNERAL DIRECTOR NAME Robert Wilhelm Funeral Home				25. DATE OF RECORD BY REGISTRAR SIGNATURE MAY 12 1982			

U.S. AIR FORCE
OFFICE OF THE SECRETARY
WASHINGTON, D.C.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

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DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		8 2 1 2 9 2 1		REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) Vivian Vincent Proctor		2a. DATE OF DEATH MONTH DAY YEAR May 18, 1982		2b. HOUR 12:30 M					
3. SEX Male		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 3 - 3 - 1894		6. AGE (IN YEARS LAST BIRTHDAY) 88 YRS		7. IF UNDER 1 YEAR MONTHS DAYS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Charles County MD			
10. CITY OR TOWN OF DEATH LaPlata		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Physicians Memorial Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Maintenance Worker		12b. KIND OF BUSINESS OR INDUSTRY Navy Yard			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland		13b. COUNTY Chas.		13c. CITY OR TOWN Waldorf		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS Box. 343, Waldorf, Md 20601	
14. FATHER'S NAME FIRST MIDDLE LAST James Proctor		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Catherine Bultor		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. 215-56-9200		17. INFORMANT Laura Watkins 7002 ADDRESS Laura Watkins Ct. Cp. Heights Md	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Ex Liposarcoma</u> 1719 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>Hemorrhage Pleural Effusions, Anemia</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>12</u> 19 <u>81</u> to <u>5-18</u> 19 <u>82</u> , that (I) (we) lost saw the deceased alive on <u>5-18</u> 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.									
22b. SIGNATURE <u>Henry Burke M.D.</u>		DEGREE		22c. DATE SIGNED 5-18-82					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Henry Burke, M.D.		22e. ADDRESS Calvert & Howard Sts. Box 591 LaPlata, MD 20646							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 5-24-82		23c. NAME OF CEMETERY OR CREMATORY Forest Hill Gardens		23d. LOCATION CITY OR TOWN COUNTY STATE Clinton P.G. Md			
24. FUNERAL DIRECTOR NAME <u>Martell Adams</u>		ADDRESS <u>Adams & Co. Inc.</u>		25a. DATE REC'D. BY REGISTRAR MAY 25 1982		25b. REGISTRAR'S SIGNATURE <u>James J. [Signature]</u>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the local health officer with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 1 2 9 2 2

REG. NO.

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) EDITH Elizabeth RANKIN			2a. DATE OF DEATH MONTH DAY YEAR MAY 1, 1982		2b. HOUR 12:18P
3. SEX FEMALE	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR Feb. 3, 1922		6. AGE (IN YEARS LAST BIRTHDAY) 60 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH CHARLES MD.	
10. CITY OR TOWN OF DEATH LA PLATA	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PHYSICIANS MEMORIAL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY own Home
13a. STATE Maryland			13b. COUNTY Charles	13c. CITY OR TOWN Waldorf	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST Noah W. Brown			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Francis Anna Wentz		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) N/A			16b. SOCIAL SECURITY NO. 66-207-12-7221		17. INFORMANT ADDRESS Clinton Wayne Rankin Same as Line 13
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIOGENIC SHOCK 4100 DUE TO, OR AS A CONSEQUENCE OF ACUTE MYOCARDIAL INFARCTION Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 5/1/82 to 5/1/82 , that (I) (we) lost saw the deceased alive on 5/1/82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE R. W. Woodring				22c. DATE SIGNED 5-1-82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) NALLAN C RAMAKRISHNA, M.D.				22e. ADDRESS WALDORF, MARYLAND 20601	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 5-5-82	23c. NAME OF CEMETERY OR CREMATORY Augusta Mem. Park		23d. LOCATION CITY OR TOWN COUNTY STATE Waynesboro Augusta Va.	
24. FUNERAL DIRECTOR NAME Huntt Funeral Home Waldorf, Maryland				25a. DATE REC'D. BY REGISTRAR MAY 4 1982 25b. REGISTRAR'S SIGNATURE James Santhorne	

U.S. DEPARTMENT OF AGRICULTURE
WASHINGTON, D.C.

Feb. 1, 1932

Mr. J. H. ...
U.S. DEPARTMENT OF AGRICULTURE
WASHINGTON, D.C.

Dear Sir:

Reference is made to your letter of January 27, 1932, regarding the matter mentioned in the enclosed letter.

The matter mentioned in the enclosed letter is being handled by the Bureau of Plant Industry, and it is suggested that you contact the Bureau for further information.

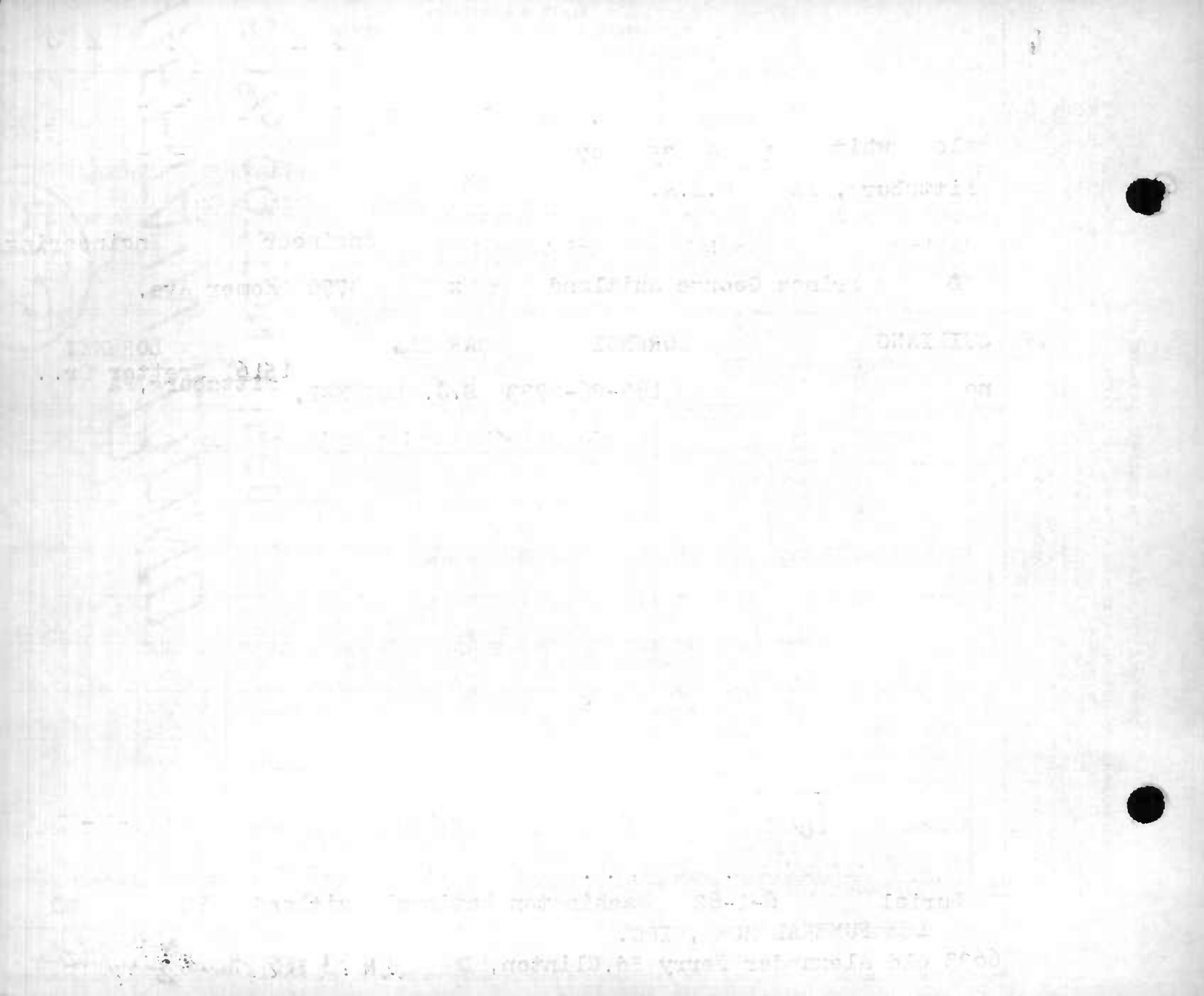
Very truly yours,
Director

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DMMH-17
(VR A15 ME (5))
15M 2/80

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 12923			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST HENRY J. SOJOURNER										2a. DATE KNOWN OF DEATH MONTH DAY YEAR 5-30-82		2b. HOUR M 5:44	
1. SEX male		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR 1 9 35		6. AGE (IN YEARS) LAST BIRTHDAY 47 YRS.		IF UNDER 1 YR. IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.		2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 5-30-82			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pittsburg, PA				7b. CITIZEN OF WHAT COUNTRY? U.S.A.				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Charles County MD.			
10. CITY OR TOWN OF DEATH LaPlata				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Physicians Memorial Hospital				12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE) Engineer		12b. KIND OF BUSINESS OR INDUSTRY Engineering			
13a. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. Prince George Suttland										13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 4700 Homer Ave.	
14. FATHER'S NAME FIRST MIDDLE LAST GUILIANO LORENZI						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST CARMELA LORENZI							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) no				16b. SOCIAL SECURITY NO. 183-26-3733		17. INFORMANT 1816 Tretter Dr., Pittsburg, PA S.J. LORENZI,							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease 4292 (b) DUE TO, OR AS A CONSEQUENCE OF (c) DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .													
ACTUAL SIGNATURE Margareta A. Korell, M.D.				TITLE (SPECIFY) Assistant				DATE SIGNED 5-31-82					
EXAMINER'S NAME (TYPE OR PRINT) Margarita A. Korell, M.D.				ADDRESS 111 Penn Street									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 6-1-82		23c. NAME OF CEMETERY OR CREMATORY Washington National Suttland				23d. LOCATION PG COUNTY MD			
24. FUNERAL HOME, INC. NAME ADDRESS 6633 Old Alexander Ferry Rd. Clinton, MD						25a. DATE REC'D. BY REGISTRAR JUN 3 1982		25b. REGISTRAR'S SIGNATURE Thomas J. Nathan					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled in by the attending physician and completely filled in by the funeral director should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 2 1 2 9 2 4 REG. NO.			
1. FOR STATE REGISTRAR				2a. DATE OF DEATH			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Alois Oscar STALLMAN				MONTH DAY YEAR 5 7 82		2b. HOUR 5:56 AM	
3. SEX MALE		4. RACE CAU.		5. DATE OF BIRTH MONTH DAY YEAR June 24, 1915		6. AGE (IN YEARS LAST BIRTHDAY) 66 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Indiana		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH CHARLES COUNTY MD.	
10. CITY OR TOWN OF DEATH LA PLATA		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PHYSICIANS MEM. HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Cabinet Maker		12b. KIND OF BUSINESS OR INDUSTRY Builder	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE 13c. CITY OR TOWN MD. CHARLES WARDORF				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS Holly Lane Box 91	
14. FATHER'S NAME FIRST MIDDLE LAST Jacob Stallman				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Bertha Lindauer			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (IF YES, GIVE YEAR OR DATES) Yes		16b. SOCIAL SECURITY NO. WW II 303-28-2437		17. INFORMANT ADDRESS Agnes E. Stallman same as 13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardiopulmonary arrest 1519 DUE TO, OR AS A CONSEQUENCE OF (b) Carcinoma Stomach. DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 4-24-1979 to 5-7-1982 , that (I) (we) lost saw the deceased alive on 4-22-1982 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) not view the body after death.							
22b. SIGNATURE Worrell				DEGREE M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 5-7-82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) G.S. RATH				22e. ADDRESS WALDORF, MD. 20601			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 5-10-82		23c. NAME OF CEMETERY OR CREMATORY St. Peter's Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Waldorf, Charles, Md.	
24. FUNERAL DIRECTOR HUNT FUNERAL HOME, WALDORF, MD. 20601				DATE RECEIVED BY REGISTRAR MAY 11 1982 REGISTRAR'S SIGNATURE			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2 entry be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by phone.

FOR
1. STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 1 2 9 2 5

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) John Herman Stamp		2a. DATE OF DEATH MONTH DAY YEAR 5-18-82		2b. HOUR 5:37^{PM}	
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Nov. 3, 1898		6. AGE (IN YEARS (LAST BIRTHDAY)) 83 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? U. S. A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Charles Co. MD.	
10. CITY OR TOWN OF DEATH La Plata	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Physician's Memorial Hosp.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Farmer		12b. KIND OF BUSINESS OR INDUSTRY Self-Employed
13a. STATE Maryland		13b. COUNTY Charles	13c. CITY OR TOWN Tompkinsville	13d. INSIDE CITY LIMITS? <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST John Herman Stamp		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ellen Stamp			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 217-36-6780		17. INFORMANT ADDRESS Grace Thorne Stamp, Tompkinsville, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Infarction 4100 DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) _____					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (1) this hospital attended the deceased from 5-18 , 19 82 , to 5-18 , 19 82 , that (1) (we) lost saw the deceased alive on 5-18 , 19 82 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Henry L. Burke		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 5-18-82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Henry L. Burke		22e. ADDRESS La Plata Md 30646			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Entombment		23b. DATE 05/21/82		23c. NAME OF CEMETERY OR CREMATORY Trinity Mem. Gardens	
23d. LOCATION CITY OR TOWN COUNTY STATE Charles Md.		24. FUNERAL DIRECTOR NAME ADDRESS Arehart Funeral Home, Inc., La Plata, Md.			
25a. DATE REC'D. BY REGISTRAR MAY 24 1982		25b. REGISTRAR'S SIGNATURE James J. Martin			

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR RECORDS. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP
DHMH-17
(VR A15 ME (1))
15M 2/80

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 12926

1. FOR STATE REGISTRAR		2. DATE KNOWN OF DEATH ESTI. <input checked="" type="checkbox"/> MONTH DAY YEAR 5-12-82										2b. HOUR M 8:32 M	
1. DECEASED NAME (TYPE OR PRINT) FRANK RAY WELCH												2c. DATE PRONOUNCED DEAD 5-12-82	2d. HOUR M 8:32 M
3. SEX male	4. RACE white	5. DATE OF BIRTH MONTH DAY YEAR 5-25-1965	6. AGE (IN YEARS LAST BIRTHDAY) 16 YRS.	7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN.	7c. DATE PRONOUNCED DEAD 5-12-82	7d. HOUR M 8:32 M	9. BALTIMORE CITY OR COUNTY OF DEATH Charles County						
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, D.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Charles County			10. BALTIMORE CITY OR COUNTY OF DEATH Charles County				
10. CITY OR TOWN OF DEATH La Plata		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Physicians Memorial Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Student		12b. KIND OF BUSINESS OR INDUSTRY High Sch.					
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)													
13a. STATE Md.		13b. COUNTY Charles		13c. CITY OR TOWN Bryans Road		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS Rt.#2 Box 168					
14. FATHER'S NAME FIRST MIDDLE LAST Francis D. Welch						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Brenda Kathy Hubbard							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO				16b. SOCIAL SECURITY NO. 212-88-9494		17. INFORMANT ADDRESS Francis D. Welch same as #13							
18. CAUSE OF DEATH (Enter only one cause per line 1a (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gunshot wounds of back and shotgun wound of back</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY 7:45 PM MONTH DAY YEAR 5-12-82		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) subject shot during altercation							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) home		21f. LOCATION STREET CITY OR TOWN COUNTY STATE Rt.2 Box 168 Bryans Rd. Maryland							
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> .													
ACTUAL SIGNATURE Margarita A. Koroll, M.D.				TITLE (SPECIFY) Assistant				MEDICAL EXAMINER			DATE SIGNED 5-13-82		
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS 111 Penn Street									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 5-16-82		23c. NAME OF CEMETERY OR CREMATORY St. Charles Cemetery				23d. LOCATION CITY OR TOWN COUNTY STATE Glymont Charles Maryland			
24. FUNERAL DIRECTOR NAME Arehart Funeral Home						ADDRESS La Plata, Md.		25a. DATE REC'D BY REGISTRAR MAY 18 1982		25b. REGISTRAR'S SIGNATURE Francis J. [Signature]			

25

2-10-1962

Mr. J. E. ...

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